Prior Authorization Request 5802 Benjamin Center Dr., Suite 105 Tampa, FL 33634

## ColoradoPAR Program Medical Review Department

QUESTIONNAIRE #11
ADULT ORTHOTICS and PROSTHETICS—ADULTS 21+

Client Name:				Colorado Medicaid ID #:					
		1				1	$\neg$		
	Start Date:		Height:		Weight:				
	information requested bel ch it to the completed Prio				v. After you	have comple	eted this form,		
1)	What is the complete diagnosis with complicating factors:								
2)	What change in the client's condition do you anticipate if the equipment is provided?				Correction [	Problem A	Alleviation		
					☐ Prevention of associated problems				
			Potential of avoiding surgery with use of orthotics or prosthetic						
Questions specific to Prostheses:									
3)	Functional level as defin	□ Level 0 □ Level 1 □ Level 2 □ Level 3 □ Level 4							
4)	Is this a replacement?	□Yes □N	No						
	a.) If this is a replacement prosthesis is	Year:							
	b.) If this is a new prosthesis, when was the amputation/ surgery performed?				Month: Year:				
Question specific to Orthosis:									
5)	5) Is this a replacement?			□Yes □N	No				
	a.) If this is a replacement orthosis issued?	ent, when was	the current						
6)	Is this orthosis:			☐ Pre-fabricated <b>or</b> ☐ Custom					
7)	What is the reason a pre appropriate?	e-fabricated de	vice is not						
8)	Please supply any additi assist us in determining request:								
Print	Prescriber Name								
Pres	Prescriber Signature				Date				

Revision Date: 09/15

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